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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
NUMBER OF THE STATUTORY
NUMBER OF THE STATUTORY

PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 001 Facility Name: Southgate Health Care Ce	7996		II. CERTI	FICATION BY A	UTHORIZED FACILITY	Y OFFICER	
	Address: 900 East 9th St. Number County: Massac	Metropolis City	62960 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider)				
	Telephone Number: (618) 524-2683 IDPA ID Number: 370993462001	Fax # (618) 524-3048		Inter	ntional misreprese	on of which preparer has a entation or falsification of e punishable by fine and/o	any information	
	Date of Initial License for Current Owners: Type of Ownership:	01/01/1964		Officer or Administrator	(Signed)(Type or Print Na	ame) Sam Thompson	3/28/2004 (Date)	
	VOLUNTARY,NON-PROFIT Charitable Corp.	X PROPRIETARY Individual	GOVERNMENTAL State	of Provider	(Title) Vice Pr	esident		
	Trust IRS Exemption Code	Partnership Corporation X "Sub-S" Corp.	County Other	Paid	(Signed) S	BEE ACCOUNTANTS' C	OMPILATION REPORT (Date)	
		Limited Liability Co. Trust Other		Preparer	_	Altschuler, Melvoin and G		
					(Telephone) (MAIL	(312) 384-6000 FO: OFFICE OF HEALT		
	In the event there are further questions about Name: Michael W. Martin Please send copies of desk review and at	Telephone Number: (312) 38			201 S. C	OIS DEPARTMENT OF I Grand Avenue East field, IL 62763-0001	PUBLIC AID Phone # (217) 782-1630	

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	er Southgate He	ealth Care Center				# 0017996 Report Period Beginning: 01/01/03 Ending: 12/31/03
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/c	ertification level(s) of	f care; enter numbei	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds	N/A		
	, ,	ŕ	o .	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		_
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of		Report Period	Report Period		
	report i criou	Ecrer of v	cure	Report Feriou	Report Ferrou		G. Do pages 3 & 4 include expenses for services or
1	74	Skilled (SNI	7)	74	27,010	1	investments not directly related to patient care?
2	/4		atric (SNF/PED)	,,,	27,010	2	YES X NO Non-allowable costs have been
3	66	Intermediat		66	24,090	3	eliminated in Schedule V, Column 7
4	00	Intermediat	,	00	21,050	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C				5	YES X NO
6		ICF/DD 16				6	
		TCT/DD TO	JI Less			—	I. On what date did you start providing long term care at this location?
7	140	TOTALS		140	51,100	7	Date started 08/25/1972
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per	iod.				YES Date N/A NO X
	1	2	3	4	5		<u> </u>
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 38 and days of care provided 2,786
8	SNF	9,341	213	3,520	13,074	8	
9	SNF/PED					9	Medicare Intermediary AdminaStar Federal (Louisville, KY)
10	ICF	23,277	5,116		28,393	10	·
11	ICF/DD	,	,		ĺ	11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	32,618	5,329	3,520	41,467	14	Is your fiscal year identical to your tax year? YES X NO
	C Dangart Oa	cupancy. (Column 5,	ling 14 divided by to	stal liganead			Tax Year: 12/31/03 Fiscal Year: 12/31/03
		line 7, column 4.)	81.15%	nai neenseu			* All facilities other than governmental must report on the accrual basis.
1	oca aays on	· · · · · · · · · · · · · · · · · · ·	0111070	_	SEE ACCOUNTAN	NTS' C	OMPILATION REPORT

	Facility Name & ID Number	Southgate Heal			#	0017996	Report Period	Beginning:	01/01/03	Ending:	12/31/03	_
	V. COST CENTER EXPENSES (through	ghout the report	t, please round t	to the nearest d	ollar)	Deelee	DI:6:-1	A 31:4	A 4!41	EOD OHE	HEE ONLY	
	O		Costs Per Gener		T-4-1	Reclass-	Reclassified	Adjust-	Adjusted Total	FOR OHE	USE ONLY	
	Operating Expenses A. General Services	Salary/Wage	Supplies	Other 3	Total	ification 5	Total 6	ments 7**	1 otai 8	9	10	
1	Dietary	149,444	9,570	6,936	165,950	5	165,950	7	165,950	9	10	1
1	Food Purchase	149,444	195,418	0,930	195,418		195,418	(24 591)	160,837			
2		106.074			, -		, -	(34,581))			2
3	Housekeeping	106,074	20,409		126,483		126,483		126,483			3
4	Laundry	69,441	11,034	50 500	80,475		80,475		80,475			4
5	Heat and Other Utilities	60.716	0.4.60	72,780	72,780		72,780		72,780			5
6	Maintenance	69,516	9,160	35,473	114,149		114,149		114,149			6
7	Other (specify):*											7
8	TOTAL General Services	394,475	245,591	115,189	755,255		755,255	(34,581)	720,674			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	980,137	140,908	55,117	1,176,162		1,176,162		1,176,162			10
10a	Therapy			297,983	297,983		297,983		297,983			10a
11	Activities	63,881	2,911		66,792		66,792		66,792			11
12	Social Services	44,869			44,869		44,869		44,869			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,088,887	143,819	358,100	1,590,806		1,590,806		1,590,806			16
	C. General Administration		, i	Í								
17	Administrative	242,367			242,367		242,367		242,367			17
18	Directors Fees				·		·					18
19	Professional Services			26,446	26,446		26,446	(784)	25,662			19
20	Dues, Fees, Subscriptions & Promotions			23,335	23,335		23,335	(11,658)	11,677			20
21	Clerical & General Office Expenses	130,080	15,854	55,027	200,961		200,961	(1,617)	199,344			21
22	Employee Benefits & Payroll Taxes			302,019	302,019		302,019	33,578	335,597			22
23	Inservice Training & Education			, , , , ,	, ,, ,		1	- /	,			23
	<u> </u>										1	

10.372

14,751

164,192

984,443

10,372

14,751

164,192

984,443

(5,013)

(2,109)

12,397

5,359

12,642

164,192

996,840

STATE OF ILLINOIS

Page 3

24

25

26

27

28

29

(sum of lines 8, 16 & 28) 1,855,809 405,264 1,069,431 3,330,504 3,330,504 (22,184) *Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification. | 3,330,504 | (22,184) | 3,308,320 | SEE ACCOUNTANTS' COMPILATION REPORT

15,854

372,447

10,372

14,751

164,192

596,142

24 Travel and Seminar

27 Other (specify):*

25 Other Admin. Staff Transportation

28 TOTAL General Administration

TOTAL Operating Expense

26 Insurance-Prop.Liab.Malpractice

^{**} See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

			Cost Per General Ledger			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			90,594	90,594		90,594	11,014	101,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,924	1,924		1,924	(1,924)				32
33	Real Estate Taxes			20,355	20,355		20,355		20,355			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,791	10,791		10,791		10,791			35
36	Other (specify):*											36
37	TOTAL Ownership			123,664	123,664		123,664	9,090	132,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	167,472	69,351	18,228	255,051		255,051		255,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):* Nonallowable Costs			142,793	142,793		142,793	(142,793)				43
44	TOTAL Special Cost Centers	167,472	69,351	237,671	474,494		474,494	(142,793)	331,701			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,023,281	474,615	1,430,766	3,928,662		3,928,662	(155,887)	3,772,775			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

^{**}See schedule of adjustments attached at end of cost report.

Ending:

0017996 Report Period Beginning:

01/01/03

12/31/03

4

VI. ADJUSTMENT DETAIL

A. The expenses

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III Column	I Z DCIO	1	2	3	1 2031
			-	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
	Laundry for Non-Patients					8
	Non-Straightline Depreciation		11,014	30		9
-	Interest and Other Investment Income					10
	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
	Sales Tax		(138)	43		13
14	Non-Care Related Interest		(1,905)	32		14
15	Non-Care Related Owner's Transactions					15
	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(1,740)	43		18
-	Entertainment					19
20	Contributions		(39,602)	43		20
21						21
22	Special Legal Fees & Legal Retainers					22
	Malpractice Insurance for Individuals					23
	Bad Debt		(29,915)	43		24
25	Fund Raising, Advertising and Promotional					25
	Income Taxes and Illinois Personal					
	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising		(11,263)	20		28
	Other-Attach Schedule See attached		(82,338)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(155,887)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (155,887)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONL	Y				
48		49	50	51	52	

Southgate Health Care Center Facility #: 0017996 01/01/2003 - 12/31/2003

Page 5 - Non-allowable Expenses

<u>Description</u>	<u>Amount</u>	<u>Ref</u>
PAC contribution	(672)	43
Cable & condo rent	(1,617)	21
Medicare & VA lab/x-ray fees	(11,923)	43
Out-of-state travel & seminar	(5,013)	24
Non-allowable travel & entertainment	(2,109)	25
Directors Insurance	(24,320)	43
Car & gas expense	(4,467)	43
Marketing expense	(11,075)	43
Tax expense	(9,249)	43
Other income	(9,692)	43
Legal (collection) fees	(784)	19
Chamber of Commerce & Kiwanis dues	(395)	20
Offset Interest Income	(19)	32
Offset Vending Income	(1,003)	2
	(82,338)	

STATE OF ILLINOIS

Page 5A

Southgate Health Care Center

ID#	0017996
Report Period Beginning:	01/01/03
Ending:	12/31/03

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	NON-REEO WILDEE EXI ENGES	s	Reference	1
2		3		2
3				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40		ļ		40
41				41
42				42
43				43
44				44
45				45
46]		46
47				47
48				48
49	Total	0		49
	See Accountants' Co.			-

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A # 0017996 Report Period Beginning: 01/01/03 12/31/03 **Ending:**

Facility Name & ID Number | Southgate Health Care Center |
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

	SUMMARY OF PAGES 5, 5A, 6, 6A	i, ob, oc, ob,	oE, or, oG, on	TINDUI									SUMMARY	_
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	ı
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	61	(to Sch V, col.	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10:
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,263)	0	0	0	0	0	0	0	0	0	0	(11,263)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,263)	0	0	0	0	0	0	0	0	0	0	(11,263)	28
	TOTAL Operating Expense				Ī									
29	(sum of lines 8,16 & 28)	(11,263)	0	0	0	0	0	0	0	0	0	0	(11,263)	29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
30	Depreciation	11,014	0	0	0	0	0	0	0	0	0	0	11,014	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,905)	0	0	0	0	0	0	0	0	0	0	(1,905)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,109	0	0	0	0	0	0	0	0	0	0	9,109	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(71,395)	0	0	0	0	0	0	0	0	0	0	(71,395)	43
44	TOTAL Special Cost Centers	(71,395)	0	0	0	0	0	0	0	0	0	0	(71,395)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(73,549)	0	0	0	0	0	0	0	0	0	0	(73,549)	45

0017996

Report Period Beginning:

01/01/03

Ending:

12/31/03

Page 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1		2			3			
OWNER	S	RELATED NURSING HOMES			OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name	City	N	ame	City		Type of Business
Jane Ann Parker	86.00							
Sam Thompson	4.67							
Jeff Thompson	4.67	N/A		N/A	A			
Shelly MacCauley	4.66							
					•		·	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES X NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	the mon	uctions	for determining costs as specified	ioi tilis ioi iii.					
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership		Costs (7 minus 4)	
-	V			e e		Ownership	© Gamzation	c (7 mmus 1)	1
-	· ·	-		Ф			J	J.	-
2	V								2
3	V								3
4	V								4
5	V								5
6	V				N/A				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s			s	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

0017996

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work					
					Compensation	Week Dev	oted to this	Compensation Included		Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
		Operations	Administrative	4.67	None	40+	66.67	Salary	\$ 170,493	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	4.67	None	40+	100.00	Salary	27,600	6(1)	2
3	Mary Lynn Thompson	Accountant	Clerical	0.00	None	40+	100.00	Salary	38,933	21(1)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 237,026		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS	Page	8
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25

	Facility Nam	e & ID Number Southgate H	ealth Care Center		# 0017996 I	Report Period Beginning:	01/01/03	Ending:	12/31/03	
	VIII. ALLOC	CATION OF INDIRECT COSTS				Name of Rel	ated Organization	N/A		
	A. Are the	ere any costs included in this repor	rt which were derived from	n allocations of centr	ral office	Street Addre				
		ent organization costs? (See instruc			X	City / State /			_	
	•	,	,			Phone Numl	per ()	_	
	B. Show t	he allocation of costs below. If nec	essary, please attach worl	ksheets.		Fax Number	()		
		<u></u>			_	_				
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6					N/A					6
7										7
8										8
9										9
10										10
11									_	11
12										12
13			<u> </u>							13 14
15									_	15
16	-									16
17									+	17
18										18
19									1	19
20			1							20
21										21
22									1	22
23										23
24										24
	+									-

25 TOTALS

Southgate Health Care Center # 0017996

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

Facility Name & ID Number

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	ì	2	-	3	4	5	6	7	8	9	10	
					Monthly				Maturity	Interest	Reporting Period	
	Name of Lender	Related		Purpose of Loan	Payment	Date of		int of Note	Date	Rate	Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1	Banterra Bank		X	Vehicle purchase	\$360.00	08/24/00	\$ 11,154	\$	08/23/03	0.1000	\$ 105	1
2	Banterra Bank		X	Vehicle purchase	\$948.00	08/24/00	29,810		08/23/03	0.0900	248	2
3	GMAC		X	Vehicle purchase	\$1,130.00	10/31/02	40,686	24,864	10/31/05	zero %		3
4												4
5												5
	Working Capital											
6	Community Bank		X	Line of Credit	demand	2/28/03	60,000		2/28/04	varies	1,269	6
7			X	Finance Charge							11	7
8			X	Accrued Interest Write-off							(1,614)	8
9	TOTAL Facility Related				\$2,438.00		\$ 141,650	\$ 24,864			\$ 19	9
	B. Non-Facility Related*					•			•			
10	Mercedes Credit		X	Vehicle - JA	\$1,415.00	5/31/03	76,104	69,509	5/31/08	0.0490	1,905	10
11								Less: Interest	ncome offset	t	(19)) 11
12								Non-allo	wable intere	st	(1,905)	12
13												13
14	TOTAL Non-Facility Related				\$1,415.00		\$ 76,104	\$ 69,509			\$ (19)) 14
								Í				
15	TOTALS (line 9+line14)						\$ 217,754	\$ 94,373			\$	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning:

01/01/03 Ending:

12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

D. Real Estate Taxes					,				
Real Estate Tax accrual used on 2002 report.	<i>Important</i> , please see the next workshee bill must accompany the cost report.	t, "RE_Tax". The real	estate tax statement and	s	17,100				
2. Real Estate Taxes paid during the year: (Indicate the	ax year to which this payment applies. If payment co	overs more than one year,	detail below.) 200)2 \$	18,755				
3. Under or (over) accrual (line 2 minus line 1).				s	1,655				
4. Real Estate Tax accrual used for 2003 report. (Detail	and explain your calculation of this accrual on the li	nes below.)		\$	18,700				
**	i. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)								
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	, 11	eal estate tax appea	board's decision.)	s					
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	20,355				
Real Estate Tax History:									
Real Estate Tax Bill for Calendar Year: 1998	15,241 8		FOR OHF USE ONLY						
1999 2000	15,768 9 16,739 10	13	FROM R. E. TAX STATEMENT FOR	R 2002 \$					
2001 2002	17,006 11 18,755 12	14	PLUS APPEAL COST FROM LINE 5	5 \$					
Current tax bill rounded up to nearest \$100 = \$18700		15	LESS REFUND FROM LINE 6	\$					
		16	AMOUNT TO USE FOR RATE CALC	CULATION\$					

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

20.	DE EONG TERM CHILE REAL	L LOIT	ile imagimie	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
FACILITY NAME	Southgate Health Care Center	COUNTY	Massac	
FACILITY IDPH LIC	ENSE NUMBER 0017996		=	
CONTACT PERSON	REGARDING THIS REPORTSam Thom	pson		
TELEPHONE (618)	524-2863	FAX#:	(618) 524-3048	
A. Summary of Re	eal Estate Tax Cos			
cost that applies home property w	ex number and real estate tax assessed for to the operation of the nursing home in Co thich is vacant, rented to other organization on D. Do not include cost for any period of	olumn D. ns, or used	Real estate tax applicabl for purposes other than	e to any portion of the nurs

(A)		(B)		(C)	Tax
Tax Index N	lumbei	Property Description		Total Tax	Applicable to ursing Home
1. 08-01-450-001		BK 150	\$	16,738.36	\$ 16,738.36
2.		All blk 150 ex triangular portion	\$		\$
3.		parcel n pt of:	\$		\$
4.		Addition to Metropolis	\$		\$
5. 08-01-451-01		BK 151	\$	524.92	\$ 524.92
6.		Addition to Metropolis	\$		\$
7. 08-01-448-002		Bk 148 - W 80 ft except N 26 ft	\$	225.02	\$ 225.02
8.		Addition to Metropolis	\$		\$
9. 08-01-449-001		Bk 149 - All Bld 149 except N 26 ft	\$	1,266.56	\$ 1,266.56
0.		Addition to Metropolis	\$_		\$
		TOTALS	\$	18,754.86	\$ 18,754.86

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services: $\underline{ YES } \underline{ X } \underline{ NO }$

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq , fl , of space used

C. Tax Bills

 $Attach\ a\ copy\ of\ the\ 2002\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2002\ tax\ bill\ which\ is\ normally\ paid\ during\ 2003.$

See Accountants' Compilation Report

Page 10A

				STATE OF ILLINOI	S			Page 11
	ity Name & ID Number Southgate H			# 0017996	Report Period Be	ginning:	01/01/03 Ending:	12/31/03
X. BU	JILDING AND GENERAL INFORM	MATION:						
A.	Square Feet: 42,62	B. General Construction Type:	Exterior	Brick	Frame Concre	ete	Number of Stories	One
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from	a Related Organizatio	n.		Rent from Completely Unro	elated
	(Facilities checking (a) or (b) must of	complete Schedule XI. Those checking (c) may complete Schedu	le XI or Schedule XII-	A. See instructions.		organization.	
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equip	ment from a Related (Organization.	X (c)	Rent equipment from Comp Unrelated Organization.	pletely
	(Facilities checking (a) or (b) must o	complete Schedule XI-C. Those checking	(c) may complete Sche	dule XI-C or Schedule	XII-B. See instruct		Jirciated Organization.	
Е.	(such as, but not limited to, apartm	ned by this operating entity or related to the nents, assisted living facilities, day trainin square footage, and number of beds/units	g facilities, day care, in	dependent living facili				
F.	Does this cost report reflect any org If so, please complete the following:	rganization or pre-operating costs which a g:	re being amortized?		YE	S X N	Ю	
1.	Total Amount Incurred:			2. Number of Years (Over Which it is Bei	ng Amortized:		
3.	Current Period Amortization:			4. Dates Incurred:				
		Nature of Costs:						
		(Attach a complete schedule deta	ailing the total amount	of organization and pr	e-operating costs.)			
XI. O	OWNERSHIP COSTS:	1	2	3	4			
	A. Land.	Use	Square Feet	Year Acquired	Cost			
	A. Lanu.	1 Resident care	185,500	197		5,000 1		
		2 Resident care	193,500	200		95,000 2		
		3 TOTALS	379,000			100,000 3		
		<u>, </u>	SEE ACCOUN	NTANTS' COMPILAT	TION REPORT	<u> </u>		

STATE OF ILLINOIS

Page 12 12/31/03 Facility Name & ID Number Southgate Health Care Center # 0017

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0017996 Report Period Beginning: 01/01/03 Ending:

	B. Bullai	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar											
	1		2	3	4	5	6	7	8	9			
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated			
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation			
4	88		1972	1972	\$ 207,276	\$	30	s 6,909	s 6,909	\$ 196,907	4		
5	37			1976	289,344		30	9,645	9,645	265,238	5		
6	10			1989	583,147	18,513	30	19,438	925	281,551	6		
7	5			1993	598,429	15,344	30	19,948	4,604	209,454	7		
8				1994	13,658	350	30	455	105	4,530	8		
	Impro	ovement Type**	•										
9	Land improve	ements		1975	7,341		10-30			7,341	9		
	Land improve			1976	2,886		20			2,886	10		
11	Building impr	ovements		1977	1,098		28			1,098	11		
12		lding improvements		1980	1,014		20			1,014	12		
13	Building impr			1981	57,891		15			57,891	13		
14	Land & build	ing improvements		1982	17,279		5-20			17,279	14		
15	Building impr			1983	675		10			675	15		
	Bushes & gra			1984	888		10			888	16		
		om & improvements		1984	13,078		15			13,078	17		
18	Building addi			1984	100,925		20	5,046	5,046	100,920	18		
19	Gravel road			1985	7,365		3-20			7,365	19		
20	Improvement			1985	17,960		15			17,960	20		
21	Fire alarm &			1985	3,568		20	179	179	3,311	21		
22	Improvement			1986	13,163		15			13,163	22		
23	Kitchen remo			1988	32,477	1,031	30	1,084	53	16,790	23		
24	Overhead doo	or/kitchen		1989	852		15	57	57	826	24		
	Flooring			1990	729		10			729	25		
	Fire alarm			1990	9,537	303	20	477	174	6,439	26		
	Dining room i			1992	1,824	58	10	93	35	1,824	27		
28		orage building		1993	17,802	565	30	593	28	6,523	28		
29	100 gal lime ta			1995	3,742		15	250	250	2,125	29		
	Drywall resid	ent rooms & bathrooms		1996	2,240	57	10	225	168	1,684	30		
31											31		
32											32		
33		·									33		
34											34		
35		·									35		
36											36		

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12A 12/31/03 Facility Name & ID Number Southgate Health Care Center # 0017

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0017996 Report Period Beginning: 01/01/03 Ending:

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar										
I	3	4) O 1 D 1	6 Life	S4 : 14 T :	8	9 14 1			
Y 400 44	Year	C 4	Current Book		Straight Line	4.11. 4	Accumulated			
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation			
37 Parking lot	1997	\$ 5,000	\$ 299	10	s 500	-01	\$ 3,250	37		
38 Flooring	1997	674	17	10	68	51	410	38		
39 Kitchen plumbing	1997	1,947	50	20	97	47	631	39		
40 Tile floor	1997	784	20	10	78	58	507	40		
41 Water softener	1997	667	17	10	67	50	435	41		
42 Interior design	1997	1,245	32	15	83	51	540	42		
43								43		
44 Flooring	1998	1,130	29	10	113	84	621	44		
45								45		
46 Roofing	1999	17,240	442	20	862	420	4,202	46		
47								47		
48 Roof - Section B	2000	31,346	437	20	1,567	1,130	5,126	48		
49								49		
50 New laundry building	2001	179,249	4,596	20	8,962	4,366	22,866	50		
51 Laundry building flooring	2001	1,219	175	10	121	(54)	304	51		
52 Roof replacement	2001	84,500	2,167	20	4,225	2,058	10,563	52		
53								53		
54 Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	3,665	54		
55 Flooring	2002	39,834	6,828	10	3,683	(3,145)	5,674	55		
56 Blinds	2002	2,473	424	10	247	(177)	371	56		
57 Awning	2002	996	171	10	100	(71)	150	57		
58 Walk in cooler repair	2002	3,361	576	10	336	(240)	504	58		
59 Lighting	2002	2,563	439	10	256	(183)	384	59		
60								60		
61 Flooring	2003	871	349	10	44	(305)	44	61		
62 Entryway Carpeting	2003	2,367	947	10	118	(829)	118	62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70 TOTAL (lines 4 thru 69)		\$ 2,481,386	\$ 56,742		\$ 88,369	\$ 31,627	s 1,299,854	70		

^{**}Improvement type must be detailed in order for the cost report to be considered complete

STAT	LE UE	TIT	INOIS

Page 13 # 0017996 01/01/03 12/31/03 Facility Name & ID Number **Southgate Health Care Center Report Period Beginning: Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	T
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 466,703	\$ 8,766	\$ 9,500	\$ 734	5-10	\$ 438,072	71
72	Current Year Purchases	1,578	902	113	(789)	7	113	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	\$ 658,870	\$ 9,668	\$ 9,613	\$ (55)		\$ 628,774	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	Resident care	1989 Chevrolet van	1989	\$ 18,500	\$	\$	\$	4	\$ 18,500	76
77	Resident care	1983 Ford pickup	1987	4,700				4	4,700	77
78	Resident care	1999 Dodge Dakota	2000	14,504	1,648	3,626	1,978	4	10,878	78
79										79
80	TOTALS			\$ 37,704	\$ 1,648	\$ 3,626	\$ 1,978		\$ 34,078	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount]
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,277,960	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,058	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,608	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 33,550	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,962,706	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	_	cumulated preciation 4	
86	1991 Mercedes Benz (1993)	\$ 46,219	\$	\$	46,219	86
87	1996 Jeep (1995)	30,199			30,199	87
88	1999 Suburban (2000)	29,810	2,712		25,741	88
89	2001 Envoy (2002)	40,686	9,114		16,774	89
90	2004 Mercedes Benz	76,104	10,710		10,710	90
91	TOTALS	\$ 223,018	\$ 22,536	\$	129,643	91

G. Construction-in-Progress

	Description	Cost		
92		\$		92
93	New Bldg-Design & permit pha	se	22,600	93
94				94
95		\$	22,600	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Fac	lity Name & I	D Number	Southgate Hea	lth Care Center		STATE OF ILLINOIS # 0017996		ort Period Beginnii	ng: 01/01/03	Ending:	Page 14 12/31/03
XII	1. Name of l 2. Does the	and Fixed Equ Party Holding		,	al amount shown below or	n line 7, column 4?]NO				
		1 Year Constructe	2 Number of Beds		4 Rental	5 Total Years of Lease	6 Total Years Renewal Optio	· I I			
3	Original Building: Additions	Constructe	N/A	Lease	Amount \$	of Lease	Kenewai Opuo	3 10.	Effective dates of cur Beginning Ending		ement:
5 6 7	TOTAL				\$			5 6 7	Rent to be paid in fut rental agreement:	ture years under	the current
	This amo		ortization of lease e lated by dividing th se					12. 13.			Cent
		t-Excluding T	YES ransportation and rental included in		Terms:	* YES]NO	14.	. /2000	<u>6</u> \$	
	16. Rental A	Amount for mo	ovable equipment:		Description:	Mattresses - 8080; Dis		Misc. small tool recreakdown of movab			
	C. Vehicle Ro	ental (See inst	ructions.)		3	4					
	1		Model Year		Monthly Lease	Rental Expense	.				
	Use		and Make		Payment	for this Period			* If there is an option		
17				\$	NT/A	\$	17		please provide com	plete details on a	ttached
18 19					N/A		18 19		schedule.		
20							20	y.	** This amount plus a	ny amortization	of lease
21	TOTAL			s		s	21		expense must agree	, , , , , , , , , , , , , , , , , , , ,	

SEE ACCOUNTANTS' COMPILATION REPORT

			S	TATE OF ILLI	NOIS			Page						
Facility N	Name & ID Number Southgate Health Car	e Center			#	0017996	Report Period Beginning:	01/01/03	Ending:	12/31/03				
XIII. EX	PENSES RELATING TO NURSE AIDE TRAINING	PROGRAMS (See in	nstructions.)		•									
A. 7	TYPE OF TRAINING PROGRAM (If aides are traine	ed in another facility	program, attach a	schedule listing t	the facility	name, addres	s and cost per aide trained in	that facility.)						
	1. HAVE YOU TRAINED AIDES	YES 2	. CLASSROOM	PORTION:			3. CLINICAL P	ORTION:						
	DURING THIS REPORT	· <u>·</u>					-							
	PERIOD?	X NO	IN-HOUSE PR	OGRAM			IN-HOUSE P	ROGRAM						
	It is the policy of this facility to only	·			·				· <u>·</u>					
	hire certified nurses aides.		IN OTHER FA	CILITY			IN OTHER F	ACILITY						
	If "yes", please complete the remainder													
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE			HOURS PER	AIDE						
	explanation as to why this training was													
	not necessary.		HOURS PER	AIDE										
B. I	EXPENSES						C. CONTRACTUAL	INCOME						
		ALLOCATI	ION OF COSTS	(d)										
				()			In the box bel	ow record the a	amount of i	ncome vour				
		1	2	3		4		ed training aide						
		Fa	cility											
		Drop-outs	Completed	Contract		Total	\$		T					
1	Community College Tuition	\$	\$	\$	\$									
2	Books and Supplies						D. NUMBER OF AID	ES TRAINED						
3	Classroom Wages (a)													
4	Clinical Wages (b)						COMPLI							
5	In-House Trainer Wages (c)						1. From this f							
6	Transportation						2. From other							
7	Contractual Payments					•	DROP-O	UTS						
8	Nurse Aide Competency Tests						1. From this f	acility						
9	TOTALS	\$	\$	\$	\$	•	2. From other	facilities (f)						

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(e)

(c) For in-house training programs only. Do not include fringe benefits.

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(1	2	3	4	5	6	7	8	
		Schedule V	Stafi	•	Outsio	de Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	than consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,423	\$ 145,370	\$	2,423	§ 145,370	1
	Licensed Speech and Language									
2	Development Therapist	10A(3)	hrs		190	11,395		190	11,395	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,354	141,218		2,354	141,218	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39(2)	prescrpts				60,736		60,736	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1, 2, 3)		167,472	291	17,467	8,615	291	193,554	12
13	Other (specify): VA Physician	39(3)			25	761		25	761	13
14	TOTAL			\$ 167,472	5,282	\$ 316,211	\$ 69,351	5,282	553,034	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Southgate Health Care Center

Provider #: 0017996 01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services Line 13 Other (specify):

		Line	Outside Practioner		
Service		Reference	Units	Cost	Supplies
	Total	_	0	0	0

Southgate Health Care Center

Provider #: 0017996 01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services Line 13 Other (specify):

	Line	Outside I		
Service	Reference	Units	Cost	Supplies
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Southgate Health Care Center XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

1 2 After

As of 12/31/03 (last day of reporting year)

		1 Operating		(2 After Consolidation*	
	A. Current Assets		perming		0110011411011	
1	Cash on Hand and in Banks	\$	191,506	\$	191,506	1
2	Cash-Patient Deposits				·	2
	Accounts & Short-Term Notes Receivable-					
3	Patients (less allowance 42,219)		666,206		666,206	3
4	Supply Inventory (priced at)					4
5	Short-Term Investments					5
6	Prepaid Insurance					6
7	Other Prepaid Expenses		29,538		29,538	7
8	Accounts Receivable (owners or related parties)					8
9	Other(specify): Employee Receivables		7,584		7,584	9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	894,834	\$	894,834	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land		100,000		100,000	13
14	Buildings, at Historical Cost		2,684,476		2,481,386	14
15	Leasehold Improvements, at Historical Cost					15
16	Equipment, at Historical Cost		696,574		696,574	16
17	Accumulated Depreciation (book methods)		(2,080,341)		(1,962,706)	17
18	Deferred Charges					18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): See schedule 17A		23,527		23,527	23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	1,424,236	\$	1,338,781	24
	TOTAL ASSETS					
25	(sum of lines 10 and 24)	\$	2,319,070	\$	2,233,615	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	114,454	\$ 114,454	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		78,125	78,125	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		10,910	10,910	31
32	Accrued Real Estate Taxes(Sch.IX-B)		18,700	18,700	32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Schedule 17A		101,961	101,961	36
37	Deferred Income-Patient Liability		70,342	70,342	37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	394,492	\$ 394,492	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		94,373	94,373	39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	94,373	\$ 94,373	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	488,865	\$ 488,865	46
					
47	TOTAL EQUITY(page 18, line 24)	\$	1,830,205	\$ 1,744,750	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	2,319,070	\$ 2,233,615	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Southgate Health Care Center, Inc.

Facility #: 0017996

Page 17 - Line 23 - Other

Unamortized Loan Costs 927
Contstruction in progress 22,600

Total - Line 9 <u>23,527</u>

Page 17 - Line 36 - Other

Accrued payroll withholding 1,984.00
Accrued IDPA audit liability 99,977.00

Total - Line 36 101,961.00

Jr CF	IANGES IN EQUITY		
		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,091,130	1
2	Restatements (describe):		2
3			3
4	Adjustments subsequent to cost report preparation	(13,144)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,077,986	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	351,097	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(598,878)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (247,781)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,830,205	24

Operating Entity Only

* This must agree with page 17, line 47.

Report Period Beginning:

Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,496,070	1
2	Discounts and Allowances for all Levels	308,580	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,804,650	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	321,886	6
7	Oxygen	3,473	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 325,359	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	95,980	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	14,694	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110,674	23
	D. Non-Operating Revenue		
	Contributions		24
	Interest and Other Investment Income***	2,007	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,007	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
	See attached schedule 19A	36,066	28
	Vending Income	1,003	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,069	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,279,759	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		755,255	31
32	Health Care		1,590,806	32
33	General Administration		984,443	33
	B. Capital Expense			
34	Ownership		123,664	34
	C. Ancillary Expense			
35	Special Cost Centers		397,844	35
36	Provider Participation Fee		76,650	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	s	3,928,662	40
40	TOTAL EATENSES (sum of fines 51 till u 59)"	Þ	3,920,002	40
41	Income before Income Taxes (line 30 minus line 40)**		351,097	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	351,097	43

* This must agree with page 4, line 45, colum	ın 4.
---	-------

^{**} Does this agree with taxable income (loss) per Federal Income
Tax Return? Yes If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Southgate Health Care Center. Inc.

Facility #: 0017996

01/01/2003 - 12/31/2003 <u>Schedule 19A</u>

Page 19: Line 28 - Other Revenue

Bad Debt Recovery 35,398 Medicare prior year settlement 668

Total - Line 28 36,066

(This schedule must cover the entire reporting period.)

		1	2**	3	4				
		# of Hrs.	# of Hrs.	Reporting Period	Averag	ge			Nι
		Actually	Paid and	Total Salaries,	Hourl	y			0
		Worked	Accrued	Wages	Wage				P
1	Director of Nursing	2,074	2,074	\$ 41,012	\$ 19.7	7 1			Ac
2	Assistant Director of Nursing	2,257	2,385	43,174	18.10		35	Dietary Consultant	
3	Registered Nurses	7,328	7,776	117,926	15.1		36	Medical Director	
4	Licensed Practical Nurses	20,188	20,990	264,783	12.6	1 4	37	Medical Records Consultant	
5	Nurse Aides & Orderlies	59,133	61,949	460,867	7.4	4 5	38	Nurse Consultant	
6	Nurse Aide Trainees	20,148	20,642	117,540	5.69	9 6	39	Pharmacist Consultant	
7	Licensed Therapist					7	40	Physical Therapy Consultant	
8	Rehab/Therapy Aides					8	41	Occupational Therapy Consultant	
9	Activity Director	2,044	2,044	22,905	11.2		42		
10	Activity Assistants	5,176	5,416	40,976	7.5	7 10	43	Speech Therapy Consultant	
11	Social Service Workers	3,997	4,154	44,869	10.80) 11	44	Activity Consultant	
12	Dietician					12	45	Social Service Consultant	
13	Food Service Supervisor	2,000	2,080	25,104	12.0	7 13	46	Other(specify)	
14	Head Cook	3,616	3,872	24,309	6.28	8 14	47		
15	Cook Helpers/Assistants	11,637	12,562	72,712	5.79	9 15	48		
	Dishwashers	4,472	4,703	27,319	5.8	1 16			
17	Maintenance Workers	5,726	5,741	69,516	12.1	1 17	49	TOTAL (lines 35 - 48)	
18	Housekeepers	17,914	18,574	111,545	6.0				
19	Laundry	10,354	10,732	69,441	6.4	7 19			
20	Administrator	2,000	2,080	71,874	34.5	5 20			
21	Assistant Administrator					21	C. 0	CONTRACT NURSES	
22	Other Administrative	2,000	2,080	170,493	81.9				
23	Office Manager	2,000	2,080	30,120	14.48				Nι
24	Clerical	8,796	9,339	99,960	10.70				0
25	Vocational Instruction					25			Pa
26	Academic Instruction					26			Ac
	Medical Director					27	50	Registered Nurses	
	Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29	Resident Services Coordinator					29	52	Nurse Aides	
30	Habilitation Aides (DD Homes)					30	1		
31	Medical Records	4,362	4,632	54,415	11.75	5 31	53	TOTAL (lines 50 - 52)	
32	Other Health Care(specify)	2,973	3,005	42,421	14.12	2 32			
	Other(specify)	ĺ	ĺ	ĺ		33			
34	TOTAL (lines 1 - 33)	200,195	208,910	\$ 2,023,281 *	s 9.68	34	SEE AC	COUNTANTS' COMPILATION RE	PORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	202	s 6,936	1(3)	35
36	Medical Director	40	5,000	9(3)	36
37	Medical Records Consultant	50	1,773	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	1,100	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	364	s 14.809		49

C. CONTRACT NURSES

		1		2	3	
		Number			Schedule V	
		of Hrs.		Total	Line &	
		Paid &	(Contract	Column	
		Accrued		Wages	Reference	
50 Reg	gistered Nurses		\$			50
51 Lic	censed Practical Nurses	1,786		52,244	10(3)	51
52 Nu	rse Aides					52
53 TO	OTAL (lines 50 - 52)	1,786	\$	52,244		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

Southgate Health Care Center, Inc.

Facility #: 0017996

01/01/2002 - 12/31/2002

Schedule 20A

	Hours	Hours	Total	Ave. Hrly.		
<u>Description</u>	<u>Worked</u>	<u>Paid</u>	<u>Wages</u>	<u>Wage</u>		
Page 20: Line 32 - Other Health Care						
Care Plan Coordinator	2,973	3,005	42,421	14.12		
Total - Line 32	2,973	3,005	42,421	14.12		

STATE OF ILLINOIS		
# 0017996	Report Period Beginning:	01/01/03

**See instructions.

					STATE OF ILLINOIS				Page	
	Southgate Health Ca	are Center			# 0017996	Rep	ort Period Begi	inning: 01/01/03 Endi	ıg:	12/31/03
XIX. SUPPORT SCHEDULES		0			D.E. I. D. C. ID. H.T.			LED E. C. L	4*	
A. Administrative Salaries Name	Function	Ownership %		Amount	D. Employee Benefits and Payroll Taxes Description		A 4	F. Dues, Fees, Subscriptions and Promo Description	tions	A 4
			\$	71,874	Workers' Compensation Insurance	s	Amount 79,344	IDPH License Fee	•	Amount 200
Michelle L Cavitt	Administrator		D			_ .			_ 3_	
Sam Thompson	Administrative	4.67%		170,493	Unemployment Compensation Insurance		20,273	Advertising: Employee Recruitment		702
			_		FICA Taxes		148,394	Health Care Worker Background Chec		1.054
			_		Employee Health Insurance		7,783	(Indicate # of checks performed 106	= ⁾ -	1,274
			_		Employee Meals		41,590	IL Health Care Association dues		7,560
			_		Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous dues		1,107
			_		Employee Retirement		5,911	Miscellaneous subscriptions		321
TOTAL (agree to Schedule V, line					Employee Recognition & Morale		32,302	Miscellaneous Licenses & fees		908
(List each licensed administrator s	separately.)		\$	242,367				Promotional advertising		11,263
B. Administrative - Other								Less: Public Relations Expense	- , -	
December				A 4					- ' -	(0.004)
Description			Φ.	Amount				Non-allowable advertising		(9,884)
NT/ 4			\$_					Yellow page advertising		(1,774)
N/A			_		TOTAL (agree to Schedule V,	e	335,597	TOTAL (agree to Sch. V,	e	11,677
			_		line 22, col.8)	Φ.	333,371	line 20, col. 8)	J =	11,077
TOTAL (agree to Schedule V, line	. 171 2)		_		E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**		
(Attach a copy of any managemen	, ,)	3 =		to Owners or Employees			G. Schedule of Travel and Seminar		
C. Professional Services	t service agreement)			to Owners of Employees			Description		Amount
Vendor/Payee	Trmo			Amount	Description Line #		Amount	Description		Amount
venuor/rayee	Type		s	Amount	Description Line #	•	Amount	O 4 (CS) (A T) I	•	
G # 1 10 1 21 4			>	26.116		_ >		Out-of-State Travel	_ 3-	
See attached Sch 21A			_	26,446						
			_		N/A			In-State Travel		
			_							
			_							
								Seminar Expense		10,372
			_					See Attached Schedule		10,372
								See Attacheu Schedule		
			_					Less: Non-allowable expenses		(5,013)
						_		Entertainment Expense	_ (-	
ΓΟΤΑL (agree to Schedule V, line	e 19, column 3)				TOTAL	\$		(agree to Sch. V,		
(If total legal fees exceed \$2500 att	ach copy of invoice	s.)	\$	26,446		=		TOTAL line 24, col. 8)	\$	5,359

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center Provider #: 01/01/03

0017996 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE Professional Services

- 1013351011M1 G01 11333	Services Rendered		Total		
Name of Vendor	(Legal, Acctg, etc)	<u>(F</u>	or this svcs)		
Altschuler, Melvoin & Glasser LLP	Accounting		10,825		
Duane Morris LLP	Legal	(107)	2,205		
Kemper CPA Group	Accounting		2,399		
Williams, Williams & Lentz	Accounting		3,275		
Whitlow, Roberts, Houston & Straub	Legal-Collections	(299)	299		
Bryant Kautz	Legal-Collections	(141)	192		
Administar Federal	Medicare Consulting		628		
Southern Reporting	Stenographer	(210)	210		
Massac County Clerk	Mortgage Release	(27)	27		
American Express Tax & Business Services, Inc.	Accounting		7,040		
Less: Garnishment related fees	Legal		(654)		
Total = Line 19, col. 3		(784)	26,446		
	Non-allowable legal fees		(784)		
	Total = Line 19, col. 8		25,662		

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year	•		
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	y Name & ID Number Southgate Health Care Center	#	0017996	Report Period Beginning:	01/01/03	Ending:	12/31/03
XX. G	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. Illinois Health Care Association - 7,560			ction of Schedule V? Yes	_	,	
(3)	Did the nursing home make political contributions or payments to a politica action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes	(14)	the patient census is a portion of the b	ouilding used for any function other isted on page 2, Section B? No ouilding used for rental, a pharmacy, xplains how all related costs were all	, day care, etc.)	For exampl If YES, attac	le,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		ssified to emply meal income to the amount.	been offset ag	gainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 7 years	(16)	Travel and Transpo	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,863 Line 10(2)		If YES, attach a	complete explanation. eparate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ N/A all travel expense relates to transporage logs been maintained? Adequa	tation of nurse	s and patients	g 0
(8)	Are you presently operating under a sale and leaseback arrangement: No If YES, give effective date of lease. N/A		e. Are all vehicles times when not	stored at the nursing home during th	e night and all	othei	tameu.
(9)	Are you presently operating under a sublease agreement? YESNO		out of the cost re	eport? Yes ty transport residents to and fr			No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over		Indicate the a	mount of income earned from p induring this reporting period.	providing suc		
	N/A	(17)		performed by an independent certific	ed public accou		
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$\frac{76,650}{V}\$. This amount is to be recorded on line 42 of Schedule V.		Firm Name: N/ cost report require been attached?	that a copy of this audit be included	with the cost re		tions for the is copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V?	ch do not relate to the provision of lo	ong term care b	een adjusted o	ou
	SEE ACCOUNTANTS' COMPILATION REPORT	(19)	performed been att	re in excess of \$2500, have legal invached to this cost report? Yes d a summary of services for all archi		,	rice:

STATE OF ILLINOIS

Page 23

Southgate Health Care Center, Inc. Facility #: 0017996 01/01/2003 - 12/31/2003

Schedule 23A

Page 23: Question 12 - Allocation of Salary Cost to Separate Lines

Salaries for Exceptional Care Program are included on Schedule V, line 39, column 1, as indicated below:

162,001
5,471
167,472
_

TEM Value 1 Cond. Value 2 Difference RESULTS COMPARE CEL SUB- LINE COL. NO. NO. WiTH CELL SCHED. NO.	COL. NO. 7 8 8 8 8 8 8 1 4 2
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income Stat. Special Cost Ctr 397,844 equal to 397,844 0 O.K. Pg19 P17 N/A 35 2 Pg4 H21H24++ N/A 38to41+43	4
ncome Stat. Prov. Partic. 76,650 equal to 76,650 0 O.K. Pg19 P18 N/A 36 2 Pg4 H25 N/A 42	4
staff- Nursing 982,177 equal to 980,137 2,040 FAILED Pg20 K11K15+ A. 1-5,24,25,27-30 3 Pg3 E19 N/A 10	1
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aff-Licensed Therapist 0 equal to 167,472 -167,472 FAILED Pg20 K17 A. 7 3 Pg4 E22 N/A 39	1
aff-Activities 63,881 equal to 63,881 0 O.K. Pg20 K19+K20 A. 9+10 3 Pg3 E21 N/A 11	1
aff- Social Serv. Workers 44,869 equal to 44,869 0 O.K. Pg20 K21 A. 11 3 Pg3 E22 N/A 12	1
aff- Dietary 149,444 equal to 149,444 0 O.K. Pg20 K22K26 A. 16-Dec 3 Pg3 E9 N/A 1	1
Iff-Maintenance 69,516 equal to 69,516 0 O.K. Pg20 K27 A. 17 3 Pg3 E14 N/A 6	1
aff-Housekeeping 111,545 equal to 106,074 5,471 FAILED Pg20 K28 A. 18 3 Pg3 E11 N/A 3	1
aff- Laundry 69,441 equal to 69,441 0 O.K. Pg20 K29 A. 19 3 Pg3 E12 N/A 4 aff- Administrative 242 367 equal to 242 367 0 O.K. Pp20 K30 K32 A 20-22 3 Pp3 F28 N/A 17	1
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ays of medicare provided 2,786 equal to 3,520 -734 FAILED Pg2 AB29 K. N/A N/A Pg2 J30 B. 8	4
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et income (loss) 351,097 equal to 351,097 0 O.K. Pg18 I15 N/A 7 1 Pg19 P30 N/A 43	2
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	B. Solved the Jappropriate Indiann Multiplians Finder to Table 1 inflation Multiplians, and lost the multiplians which correspond with the later and the product part have solviulated. Contract Entertain Multiplian Contract Collection Multiplian.	:			
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	Serie Land Leiterte Bartier Leit program, General Bartiers Bartier Blog Edit Updated General Beniters Cost 2 Marling New York General Administration Cost	\$76,00 \$76,00 \$70,20 \$10,20 \$1,07,00			
	from Day Lilly's the appropriate multiplier from Table New Yolds General Service Cod (May Lill General Administration Hallyler (Day Lill	\$76,200			
	Opinion Common Devices Cod 3 Tetal Opinion Depart Codes (5 + 2	\$1.507,604			
	STEP 1 Convert Total Updated Support Cents (C.3) to Per Georgia. Use one of the two procedures before to compute your stem conto. CALCULATED PER DESIGNATIVE CO.	EM 34			
	A. Fine surregarray (Cree Report, Peops 2, Baheshide SLC): angulin or almost \$1 persons, duting your held updated support costs (Slay SLC), a denotify the held patient dates Cree Street, Peop 2, Sateshide SLC Colores SLays 14				
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	Lear (ii) have the result and calculate some hird of the difference. Then activitie are abive difference in the behalf parties days to be disting your adjusted recognity. Send dains your trial quintered largers Ceraby (line) (i. C.) above by your adjusted in emplancy.				
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	One through difference From Total Patient Class	\$1,00 0720 64407 5490 64407 2010 64407 64407 64408 6510764 66108			
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	A. If your support notice per dam from STEP is a squal in a gaster-han for 70th percentile for your PEA, then your				
	A. From targets bench per dates benc USFF in a sparlin to general teaching process that have been proceeded as possible to the large and the period of the p				
	Indicates your support seeks you does and the Tills personnile use below in Table 6. Use the belowing promotive to adminish your rate Till Personnile Flade to your trible Mena Regions' Daniel Per Dani	EU-00 EH-34			
	Difference Multiply the Difference by	45.00			
	Consider of the Cilibronian Plan Support Conto Per Clear Support Sale if another are infrared 20th and 70th parameter	\$12.60 \$3.30 .41.66 .44.5 .41.50 .44.50 .44.50 .44.60			
	When which the prints Description Description Description				
	percentile rate up to a seeling. This seeling is expect to the percent of the difference between the 20th and 20th percentiles part 500. The entiting to apach 100.00 is brief in Table 10. Use the following proceedings to calculate poor rate				
	Til Personnile Files har provintili. Minus Respons Caris Per Dans Differense Ministrative Performance	41-8 41-8			
	Constitution of the College of the C	413			
	Enter the Lower of the Tan Januaria Plan Support Cents Per Cler	41.330 434.36			
	Deposit finite if suppost code loss than 30th personalise O VOURTHAM, TOTAL SUPPOSIT AUS bear A, B, or C also	500.00 40.00			
	Tith Percentia in 30th Percentia in	E21 63			

Change print Orientation!		OST REPORTHI	11/04/05	01:19:07 PM						
Facilty Name: Southgate Bookh Care Contro	COSTS IN	SLUDED ON PAGES 12 THRU 12D ST	ART AT CELL OS	-	0017996					
HSA No.:		5 Own or Rent? (O or R)	Own or Ro	ent Beginning:						
IF RENTED, have facilities been continously rented										
from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1979?		N								
Cost Report Pd:		Licensed Beds:	140 Total Pati		41,497					
Begin	66/86/99	Licensed Red Days:	51,100 % Occupie		81.15%					
End	1231/03		Capital Da	lys .	47,523					
1989 Property Tax COST:		(Actual dollar amount 1989 taxes)								
1991 Property Tax RATE:		(Inflated dollar amount divided by 1961 capital days)								
DV 1991 Canital Bate:		(Erom from 797)								

CAPITAL CALCULATIONS	
	Calculation
	Column
A. Determine the base year for your building from Work Table A	1988
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	2401300
Total licensed bads from cost report Page 2, Line 7, column 3 Line 1 divided by Line 2	140 917 704
Regional construction inflator from Table 2	139
5. Suilding specific historical Cost ber bed (Line 3 * Line 4, round to even \$)	24105
C. Obtain the Linform Building Value from Table 1	24102
D. The capital rate will be calculated through a blending of the uniform	
building value from Line C and the building specific historical cost per bed from Line RS	
1. Suilding specific historical cost from Line SS	24105
Uniform building value from Line C Add Lines 1 and 2	24102 46207
Add Lines 1 and 2 Divide by 2 to obtain average	49207 24104
Livide by 2 to obtain average Enter 120% of line C.	28108
6. The blended value is the lesser of Line 4 or Line 5	24104
E. Divide the blended value from step D by 239 days to obtain a per diem	71.1002
blended value investment	
F. Multiply the per diem blended value from step E by the applicable rate of	7.82
neturn to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.12% for 1978 and older base years.)	
G. Add \$2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	10.32
 Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FYSri.) 	
Enter the FY 91 capital rate	
Subtract the FY 91 property tax rate	
PY 91 rate without tax Multiply Line III by 115%	x 1.15%
5. Implementation capital rate	
J. Property Tax	
J. Property Tax Property Taxes are taken from the Long Term Care Property Tax Statement	
which was submitted to the Department of Public Aid during FYRD.	
Reimbursement for real estate taxes is based upon the actual 1991 taxes for	
which the nursing homes were assessed. The formula used is a follows:	
Property Tax Expense (Long Term Care Property Tax	0
Statement, Column D, Total) 2. Divided by: Capital Days (see below)	47.500
Divided by: Capital Days (see below) Equals: Per Diers Cost	47,523 50.00
Times: Property Tax Inflator (Table 3)	1,00753
5. Equals: Updated Property Tax Cost	0
Capital Days	
The capital days are the higher of the actual census (Page 2, Schedule III-R, Column 5. Line 14) or 92% of licensed bed days (page 2, Schedule III-A.	
Column 6, Line 14) or 90% or licensed bed days (page 2, schedule III-A, Column 4, Line 7 * 90.)	
1. Total Patient Davis	41.467
2. Total Licensed Red Days * .93	47523
Capital Days (higher of Line 1 or Line 2)	47,523
K. Total Capital Rate for FY 94	
	10.32
Enter the greater of the simplified system rate from Line H or the	
implementation capital rate from Line I	
Croter the greater of the simplified system rate from Line H or the implementation capital rate from Line I Add Property Tax from Line J Total capital rate rated Lines 1 & 2: Total capital rate rated Lines 1 & 2:	0 10 10

			Year					Year						
_					Columns					Columns		Table 1 Uniform	hulding Value	
988			(A)	Cost	(A)*(B)	Linked		(A)	Cost	(A) * (B)	Linked			
_		Leaf	2 digits only	(2)	(0)	Page		Last 2 digits only	(8)	(C)	Page		Inform Building Val	
	1		72	207276	14923972	12	67	A	- A	, A	129			
	2	2	76	299344	21990144	12	97 98	i	- 6	- 6	129	Sass year	4,7,949	1,2,3,4,5,1
200	2	2	89	593147	\$1900083	12	99				120	1970	4114	3766
140	4	4	93	599429	55653697	12	100			- 1	120	1971	5348	4090
724	6	5		43050	1293952	12	101				100	1972	6600	6000
1.26	i i	i i	94 75	13658 7361	550575	12	102	- 1	- 1	- 1	12C 12C	1972	6583 7817	6006 7155
1105	7	7	76	2006	219226	12	100			- 1	120	1974	9051	8285
1100				1700	04546	12	104			- 1	190	1975	10095	9415
1102			77 80	1014	81120	12	104				120	1976	11519	10545
1982	10	10	81	57891	4689171	12	106			- :	120	1977	12754	11975
	10	10	81	57991	4669171	12	106				190	1877	12/14	11975
	11	11	82	17279	1416878	12	107				120	1979	12988	12904
	12	12	83	675	56025	12	108				120	1979	15222	13934
	13	13	84	888	74592	12	109				120	1990	19459	15064
	54	14	84	13079	1096552	12	110				120	1991	17691	16194
1105	15	15	84	100925	8477700	12	111				120	1992	19925	17324
1102	19 17	16	85	7365	626025	12	112				120	1993	20159	18453
227	17	17	85	17960	1526600	12	113				120	1994	21393	19593
1104	19	18	85	2568	303290	12	114				120	1995	22628	20713
922	19	19	86	13163	1132018	12	115				120	1996	23992	21943
104	20		86		2857976	12	116				120	1997	25099	
	21	21	89	952	75828	12	117				120	1999	26330	24102
022	22	22	90	709	65510	12	110				120	1999	27554	25232
	22	99	90	9517	858220	12	119	- 1		- 1	120	1990	20799	96962
	24	24	92	1924	197908	12	120	- 1	- 1	- 1	120	1991	30023	27492
7.82	25	25	93	17902	1655586	12	121				120	1992	31267	29622
	20	20	96	3742	355490	12	122				120	1992	32501	29751
	27	27	96	2240	215040	12	122				120	1994	22726	20091
	28	29		0	0	12	124				120	1995	34970	32011
	28	28		0		12	124				190	1990	349/0	20011
2.5	29	29		0		12	125				120	1996	36204	22141
	30	30		0		12	126				120	1997	37438	34271
1.32	31	31		0		12	127				120	1998	39673	35400
	22	22		0		12	128				120	1999	29907	
	33 34	22 24	97	0		12	129				120	2000	41141	27060
	34	34	97	5000	495000	12A	130							
	35	35	97	674	65379	12A	131				120	Use the 1970 up	lues for all years pr	or to 1970
0	36	36	97	1947	199859	12A	132				120			
0	37 38	27	97	794	76048	12A	122				120			
0	28	38	97	667	64699	12A	134		- 6	- 6	120			
	29	29	97	1245	120765	12A	135				120			
	40	40		0		12A	136				120			
	41	41	60	1150	110740	124	197				120			
	42	42	- 0			12A	138	i	- 6	- 6	120			
	49	43	99	17240	1706760	12A	139				120			
		44		0	1100100	12A	140				120			
	44 45	45	100	21246	2134600	12A	141	- 1	- 1	- 1	120			
	46	46		21340	21,240,0	12A	142			- 1	120			
	49	**		179249										
	47	47	101		19104149	12A	143				120			
0	48	48	101	1219	123119 8534500	12A	144				120			
	49	49	101	84500	8534500	12A	145				120			
523	50	50		0		12A	146				120			
100	\$1	51	102	97732	9900004	12A	147				120			
1753	52	52	102	29934	4063068	12A	148				120			
0	53	53	102	2473	252246	12A	149				120			
	54	54	102	996	101592	12A	150				120			
			102			12A	151							
	56	54	102	2563	291429	12A	152				120			
	57	67		0		12A	153				120			
	58		103	871	89713	12A	154				120			
	59	59	103	2367	243901	12A	155	- 1	- 1	- 1	120			
467	60	60				12A	156			- 1	120			
523	41	61	- 1			12A	167			- 1	120			
523	62					12A	158			- 1	120			
14.4	60	62	- 1	i i	- 1	12A	159	- 1	- 1	- 1	120			
	4	64	- 1		- 1	124	160			- 1	100			
	65	66				12A	160				120			
	66	66				128	161				120			
132	67	67				128	162				120			
	66	66				128								
132		69				128								
	69 70	70		0		128								
	/0													
	71 72	71 72		0		128		lase year:	O'Total of Column I	a form Non				
	72	72				128		www.column.c	- rener on Column I	- mase Year				
	73	73				1290		220377983						
	74	74				128		220377983	2481386	88.81241492				
	75 76	75 76		0		128			Rase Year =	1999				
	79	74				129			state Year =	1966				
	77	77		0		129								
	79	79		0		129								
	79	79		0		129								
	80	80		0		129								
	81	81		0		129								
	82	82		0		129								
	83	83		0										
	84	84		0		129								
	85	65		0		129								
	86	86		0		129								
	87	87		0		128								
	88	68				128								
	89	69		0		128								
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	91	91				128								
	92	92			- 1	128								
	90	90				128								
	94	94			- 1	129								
	16	96	- 1			128								
		99				128								
	99	99		0		1286								

Transferring Symmetric S	2 column	
For Part New park plant Recommender Part Recommender Part Recommender Part Recommender Part Recommender Part Recommender Part Pa		
Tage 12.14 0 2.42 1 2.7		
1960 6.20 6.60 6.29 6.64 5 1.002/23 1.962 6.67 6.62 6.65 2 2 1.006 6.67 6.62 6.67 6.6		
964 5.67 5.52 560 587 2 1,036 962 5.67 5.52 560 587 3 1,0333 963 5.67 5.52 560 5.87 4 1,03323 964 5.67 5.2 560 5.87 5 1,03753 966 5.67 5 1,03264 5 7 1,02564 966 5.36 5.30 5.35 5.55 7 1,02564	HSA	4
1962 5.67 5.52 5.66 5.87 3 10333 1962 5.67 5.52 5.66 5.87 4 1.03352 1964 5.67 5.52 5.66 5.87 5 1.03352 1964 5.67 5.52 5.66 5.67 5 1.03552	1	
1963 5.67 5.52 5.66 5.87 4 1.033322 1964 5.67 5.52 5.66 5.87 5 1.03253 1965 5.67 5.52 5.66 5.87 6 1.02366 1966 5.06 5.20 5.35 5.55 7 1.03264	2	
1964 5.67 5.52 5.66 5.67 5 1.02753 1965 5.67 5.52 5.66 5.67 6 1.0296 1966 5.36 5.20 5.35 5.55 7 1.02564	3	
1965 5.67 5.52 5.66 5.87 6 1,02366 1966 5.36 5.23 5.35 5.55 7 1,02054	4	
1966 5.36 5.23 5.35 5.55 7 1.02054	5	
	7	
1968 4.85 4.71 4.83 5.03 9 1.01215		
1969 4.61 4.48 4.59 4.79 10 1.0215	10	
1970 4.38 4.25 4.36 4.56 11 1.03527	11	
1971 4.01 3.89 3.98 4.15		
1972 2.64 3.53 3.63 3.78		
1973 3.36 3.26 3.36 3.48		
1974 2.08 2 2.09 2.19		
1975 2.83 2.77 2.8 2.91		
1976 2.73 2.65 2.74 2.62		
1977 2.57 2.48 2.55 2.68		
1978 2.37 2.29 2.38 2.49		
1979 2.18 2.12 2.21 2.32		
1960 1.96 1.92 2.02 2.08		
1981 1.8 1.76 1.86 1.91		
1992 167 160 172 176		
1983 1.54 1.5 1.57 1.65		
1984 1.51 1.47 1.55 1.62		
1985 1.49 1.45 1.5 1.59		
1986 1.46 1.42 1.46 1.55		
1967 146 14 143 152		
1988 1.4 1.36 1.39 1.46		
1989 1.35 1.33 1.35 1.41		
1990 1.32 1.31 1.33 1.34		
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1993 125 124 125 123		
1994 1.22 1.22 1.22 1.19		
1996 12 12 1.19 1.17		
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1999 1.04 1.04 1.04 1.04		
2000 102 102 102 100		
2001 100 100 100 100 100		
2002 100 100 100 100		

					Reclass-	Reclassified		Adjusted
	Salaries	Supplies	Other	Total	ifications	Total	Adjustments	Total
Dietary	149,444	9,570	6,936	165,950	0	165,950	0	165,950
Food Purchase	0	195,418	0	195,418	0	195,418	-34,581	160,837
Housekeeping	106,074	20,409	0	126,483	0	126,483	0	126,483
4. Laundry	69,441	11,034	0	80,475	0	80,475	0	80,475
Heat and Other Utilities	0	0	72,780	72,780	0	72,780	0	72,780
6. Maintenance	69,516	9,160	35,473	114,149	0	114,149	0	114,149
Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	394,475	245,591	115,189	755,255	0	755,255	-34,581	720,674
Medical Director	0	0	5,000	5,000	0	5,000	0	5,000
	980,137		55,117	1,176,162	0	,		-,
10. Nursing & Medical Records	960,137	,		297,983	0			
10a. Therapy	-	-	297,983			,		,
11. Activities	63,881	,	0	66,792	0	,		,
12. Social Services	44,869		0	44,869	0	,		,
13. Nurse Aide Training	0		0	0	0			
14. Program Transportation	0		0	0	0			
15. Other (specify)*	0	-	0	0	0		-	-
16. Total Health Care & Programs	1,088,887	143,819	358,100	1,590,806	0	1,590,806	0	1,590,806
17. Administrative	242,367	. 0	0	242,367	0	242,367	0	242,367
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	26,446	26.446	0	26.446	-784	25.662
20. Fees, Subscriptions & Promotion	n 0	0	23,335	23,335	0	23,335	-11,658	11,677
21. Clerical & General Office	130,080		55,027	200,961	0	-,	,	,
22. Employee Benefits & Payroll	0		302,019	302,019	0	,		,
23. Inservice Training & Education	0		002,010	002,010	0	,		
24. Travel and Seminar	0	-	10,372	10,372	0	-	-	-
25. Other Admin. Staff Trans	0		14,751	14,751	0	- , -	-2,109	,
26. Insurance-Prop.Liab.Malpractice	-	-	164,192	164,192	0	, -	,	,
27. Other (specify)*	. 0		0	0	0	,		,
28. Total General Adminis	372,447		596,142	984,443	0			
26. Total General Adminis	312,441	10,004	390,142	904,443	U	904,443	12,397	990,040
29. Total General Administrative	1,855,809	405,264	1,069,431	3,330,504	0	3,330,504	-22,184	3,308,320
30. Depreciation	0	0	90,594	90,594	0	90,594	11,014	101,608
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,924	1,924	0	1,924	-1,924	. 0
33. Real Estate	0		20,355	20,355	0	, -	,	
34. Rent - Facility & Grounds	0		0	0	0	,		,
35. Rent - Equipment & Vehicles	0		10,791	10,791	0		0	
36. Other (specify):*	0	-	0,701	0	0	-, -		
37. Total Ownership	0		123,664	123,664	0			
37. Total Ownership	U	U	123,004	123,004	U	123,004	9,090	132,734
38. Medically Necessary T	0		0	0	0			
Ancillary Service Cent	167,472	,	18,228	255,051	0	,	0	,
40. Barber and Beauty Shop	0		0	0	0			
41. Coffee and Gift Shops	0		0	0	0			
	42 0		76,650	76,650	0	,		,
43. Other (specify):*	0	0	142,793	142,793	0	142,793	-142,793	0
44. Total Special Cost Ce	167,472	,	237,671	474,494	0	, -		,
45. Grand Total	2,023,281	474,615	1,430,766	3,928,662	0	3,928,662	-155,887	3,772,775

	Operating	After Consolidation
General Service Cost Center		
Cash on hand and in banks	191,506	,
Cash - Patient Deposits	0	
Accounts & Notes Recievable	666,206	
4. Supply Inventory	0	
5. Short-Term Investments	0	
6. Prepaid Insurance	0	
7. Other Prepaid Expenses	29,538	,
8. Accounts Receivable-Owner/Related Party	7.504	
9. Other (specify):	7,584	
10. Total current assets	894,834	894,834
LONG TERM ASSETS	0	0
11. Long-Term Notes Receivable	0	
12. Long-Term Investments 13. Land		
14. Buildings, at Historical Cost	100,000 3,381,050	
15. Leasehold Improvements, Historical Cost	3,361,030	
16. Equipment, at Historical Cost	0	
17. Accumulated Depreciation (book methods)	-2,080,341	-2,080,341
18. Deferred Charges	2,000,041	
19. Organization & Pre-Operating Costs	0	
20. Accum Amort - Org/Pre-Op Costs	0	
21. Restricted Funds	0	
22. Other Long-Term Assets (specify):	0	
23. other (specify):	23,527	
24. Total Long-Term Assets	1,424,236	
25. Total Assets	2,319,070	
CURRENT LIABILITIES	,,	,,
26. Accounts Payable	-114,454	-114,454
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	-78,125	-78,125
31. Accrued Taxes Payable	-10,910	-10,910
32. Accrued Real Estate Taxes	-18,700	-18,700
33. Accrued Interest Payable	0	
34. Deferred Compensation	0	
35. Federal and State Income Taxes	0	
36. Other Current Liabilities (specify):	-101,961	
37. Other Current Liabilities (specify):	-70,342	,
38. Total Current Liabilities	-394,492	-394,492
LONG TERM LIABILITES	0.4.0=0	0.4.0=0
39.Long-Term Notes Payable	-94,373	,
40.Mortgage Payable	0	
41.Bonds Payable	0	
42.Deferred Compensation	0	
43.Other Long-Term Liabilities (specify):	0	
44.Other Long-Term Liabilities (specify):	04 272	
45.Total Long-Term Liabilities	-94,373	,
46.Total Liabilities 47.Total Equity	-488,865 -1,128,011	
47.Total Equity 48.Total Liabilities and Equity	-1,616,876	
TO. I Otal Elabilities and Equity	-1,010,070	-1,010,076

Gross Revenue - All levels of Care Discounts and Allowances for all Levels	Balance per Medicaid Trial Balance -3,496,070 -308,580	
Subtotal - Inpatient Care 4. Day Care 5. Other Care for Outpatients 6. Therapy 7. Oxygen	-3,804,650 0 0 -321,886 -3,473	
Subtotal - Anciliary Revenue 9. Payments for Education 10. Other Governmental Grants 11. Nurses Aide Training Reimbursements 12. Gift and Coffee Shop 13. Barber and Beauty Care 14. Non-Patient Meals 15. Telephone, Television, and Radio 16. Rental of Facility Space 17. Sale of Drugs 18. Sale of Supplies to Non-Patients 19. Laboratory 20. Radiologyand X-Ray 21. Other Medical Services 22. Laundry	-325,359 0 0 0 0 0 0 0 0 -95,980 0 0 0 -14,694 0	
Subtotal - Other Operating Revenue 24. Contributions 25. Interest and Other Investments Income	-110,674 0 -2,007	
Subtotal - Non-Operating Revenue 27. Other Revenue (specify): 28. Other Revenue (specify): Subtotal - Other Revenue 30. Total Revenue 31. General Services 32. Health Care 33. General Administration 34. Ownership 35. Special Cost Centers 35. Provider Participation Fee 37. Other 40. Total Expenses 41. Income Before Income Taxes 42. Income Taxes 43. Net Income or Loss for the Year	-2,007 -36,066 -1,003 -37,069 -4,279,759 755,255 1,590,806 984,443 123,664 397,844 76,650 0 3,928,662 -8,208,421 0 -8,208,421	

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Page
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23 Provider Participation fee is linked from page 4
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